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Clarifying and Expanding Concepts of Cross-Jurisdictional Sharing: Early Lessons Learned from Conducting QI with Georgia's Health Districts

William C. Livingood
University of Florida

Nandi A. Marshall
Georgia Southern University, nmarshall@georgiasouthern.edu


Angela Peden
Georgia Southern University, apeden@georgiasouthern.edu

Ketty Gonzales
East Central Health District

Gulzar H. Shah
Georgia Southern University, gshah@georgiasouthern.edu

See next page for additional authors

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Authors

William C. Livingood, Nandi A. Marshall, Angela Peden, Ketty Gonzales, Gulzar H. Shah, Dayna S. Alexander, Alesha Wright, Russell B. Toal, Lynn S. Woodhouse, and DeAnna Keene

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Presenters:

Gulzar H. Shah, PhD, MStat, MS and Dayna S. Alexander, MSPH, CHES

Authors:

William Livingood, Nandi Marshall, Angela Peden, Ketty Gonzalez, Gulzar H. Shah, Dayna Alexander, Alesha Wright, Russell Toal, Lynn Woodhouse , DeAnna Keene

Georgia Public Health PBRN, State Coordinating Center
Jiann Ping Hsu College of Public Health, Georgia Southern University

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- No Disclosures to declare.



Gaps in Evidence

- Organizing LHDs for Economies of Scale
 - Need and Benefits
 - Advantages and disadvantages of different approaches
 - Best practices
- Role & models: Cross Jurisdictional Sharing (CJS)
- Role & models of regionalization-districts for CJS
- Opportunities for CJS – Multi Jurisdictional Entity



Overlapping Terms

(not always used consistently)



- **Cross Jurisdictional Sharing:** sharing of services, resources and functions across multiple public health agencies and jurisdictions (RWJF CFP on CJS) ;
- **District:** term typically describes an intermediate administrative structure between the state-level agency and LHDs (Beitsch) ;
- **Region:** one or more towns, cities or counties linked to provide public health services to a geographic area (Tidwel); (definition may apply to district)
- **Multi Jurisdictional Entity:** more than one LHD formally and demonstrably sharing resources for joint application for accreditation. (PHAB)



Outline

- Context of Georgia Model of CJS
- Overview of Study leading to these findings
- Findings - Lessons Learned from CJS in Georgia's Health Districts
- Conclusions – Potential of Districts for CJS, Multi jurisdictional entity, and QIC



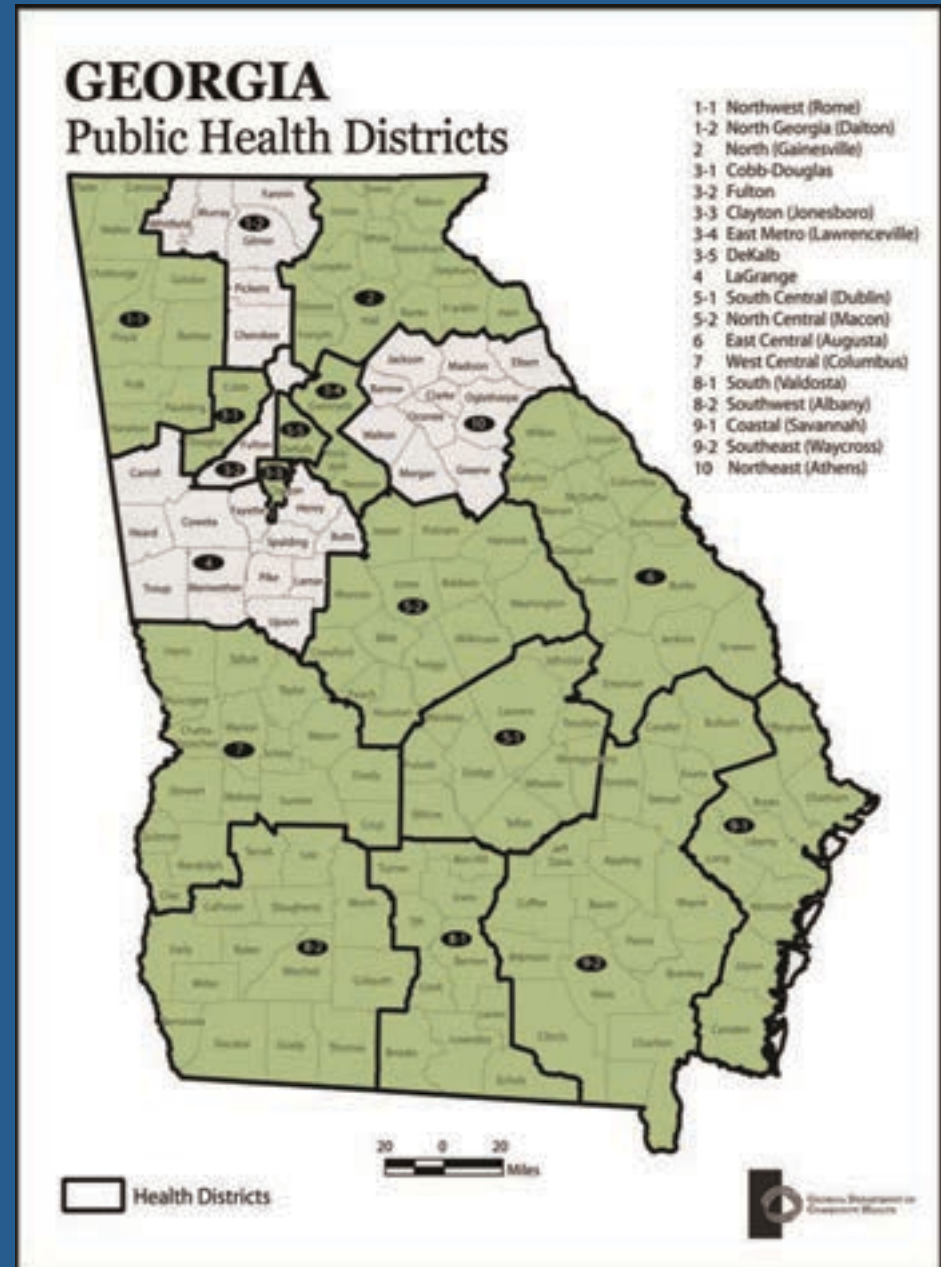
Presentation Objectives

Upon completion of this presentation, participants will be able to:

- Discuss need for economies of scale for LHD QI and accreditation performance;
- Describe approaches to obtaining economies of scale from cross jurisdictional sharing (CJS);
- Identify opportunities for CJS among LHDs through regionalization.

Georgia

- 159 counties
- Population range:
1,863 – 1,014,932
- *Green highlight -
Districts participating
in GA PH PBRN studies*



Selected Demographics*

Key Findings	US	GA	FL	NC	SC	AL	TN
Median Income	\$52,029	\$50,834	\$47,802	\$46,574	\$44,695	\$42,586	\$43,610
Persons below poverty	13.2%	14.7%	13.3%	14.6%	15.7%	15.9%	15.5%
High school graduation rate	68.6%	55.9%	53.9%	65.2%	56.5%	61.5%	66.9%
Population per square mile	87.4	168.4	350.6	196.1	153.9	94.4	153.9
Infant Morality per 1,000	6.9	8.2	7.2	8.5	9.0	9.1	8.7
Adult obesity rate	63.0	64.6%	60.1%	65.7%	65.8%	67.9%	67.9%

*Woodhouse et al, 2011. Deep South Public Health System Study, APHA

Select Regional/District Public Health Systems*

Key Findings	GA	FL**	NC	SC	AL	TN
Level of integration with local HD and local BOH	High	NA	High	Low	Varies	Low
Level of integration with state	High	NA	Low	High	High	High
Employment (state, county, regional or mix)	Mix	NA	Local	State	Mix	State

*Woodhouse et al, 2011. Deep South Public Health System Study, APHA

** FL statutes allow for two or more county structures, but none currently exist



GAPHPBRN Activities

- PBRN QI-QS: *Health Districts as QI Collaboratives*
- Quality Improvement Technical Assistance and Evaluation (October 2011 – March 2012)
- Accreditation Readiness (August 2012 – December 2012)
- Georgia Public Health District Accreditation Pilot Program (October 2012 – March 2014)
- Assessing Georgia's Health Information Exchange Systems (October 2012 – March 2013)



Purpose of Study

Previous study established Districts as QICs



Qualitative study to develop understanding of Districts in facilitating public health QI and Accreditation:

- Examine variations in CJS among districts
 - Assess differences in district structure related to QI and CJS
 - Identify foundations for variations
- Clarify role of Districts in facilitating QI among County Health Departments
- Clarify role of Districts in supporting Essential Services, organization management, and local agency accreditation
- Assess role of PBRN related to District QI



Data Sources

- **Qualitative data collection:**
(data collected from May 2012 to Present)
 - Direct observations of group dynamics
 - Interviews with QI teams members
 - Communication Logs/Project site timelines
 - Weekly GAPHPBRN team meetings notes
 - Archival review of previous research findings, statutes and reports
 - Interviews with key informants
 - Feedback from District Directors and District QI Coordinators



Qualitative Analysis

(commonly used processes)

- Iterative - emergent process, adjusting collection to new information (ongoing analysis & adjustment of information gathering);
- Analysis based on concepts presented in literature and previous experience;
- Thematic analysis emergent as concepts/themes were illuminated by research team.

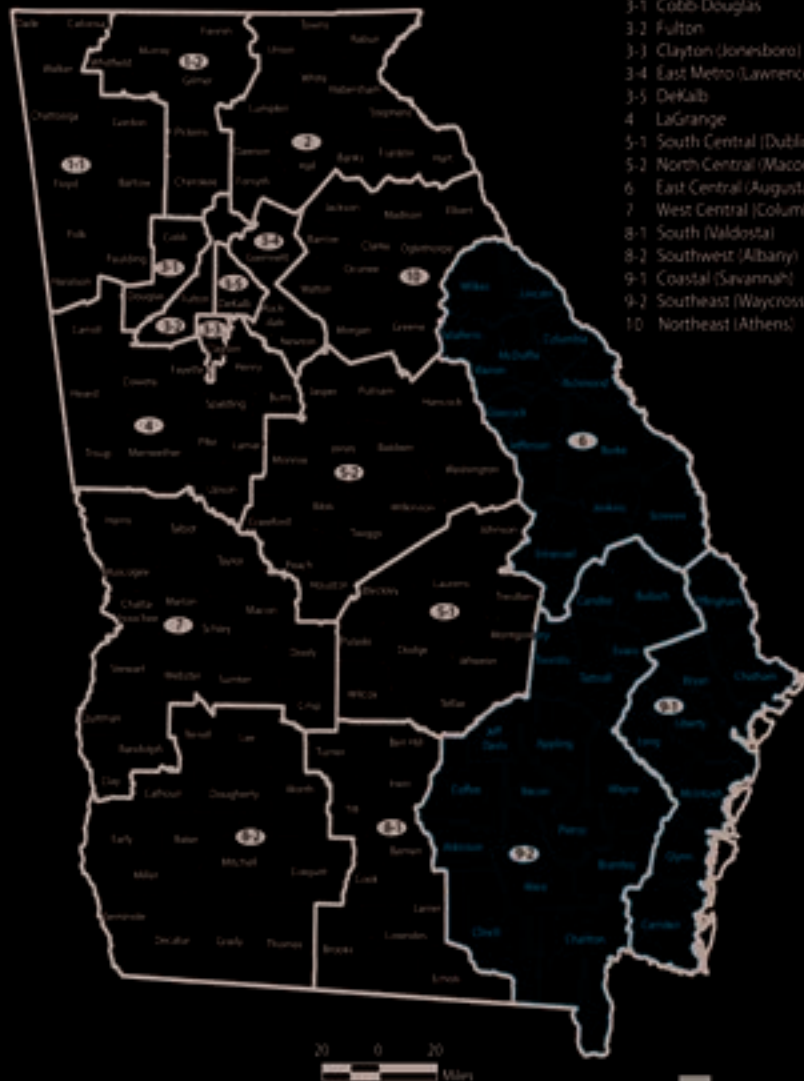


Three CJS Districts

- East Central Health District (District 6)
 - 13 counties with a total pop. of 464,544
 - QI focus: Increase teen pregnancy clinic use; reduce wait times
 - Quantitative data: Routing slips and teen clinic wait times
- Coastal Health District (District 9-1)
 - 8 counties with a total pop. 581,129
 - QI focus: Improve HIV prevention and control; increase testing
 - Quantitative data: Number of HIV tests
- Southeast Health District (District 9-2)
 - 16 counties with a total pop. of 368,543
 - QI focus: Improve HIV prevention and control; improve reporting
 - Quantitative data: CAREWare and State Performance Measures

GEORGIA

Public Health Districts



- 1-1 Northwest (Rome)
- 1-2 North Georgia (Dalton)
- 2 North (Gainesville)
- 3-1 Cobb-Douglas
- 3-2 Fulton
- 3-3 Clayton (Jonesboro)
- 3-4 East Metro (Lawrenceville)
- 3-5 DeKalb
- 4 LaGrange
- 5-1 South Central (Dublin)
- 5-2 North Central (Macon)
- 6 East Central (Augusta)
- 7 West Central (Columbus)
- 8-1 South (Valdosta)
- 8-2 Southwest (Albany)
- 9-1 Coastal (Savannah)
- 9-2 Southeast (Waycross)
- 10 Northeast (Athens)

Study Area

- 37 Counties
- 4 Metropolitan Statistical Areas:
 - Coastal Health District
 - Savannah
 - Hinesville-Fort Stewart
 - Brunswick
 - East Central Health District
 - Augusta-Richmond Co.
- Largest Counties:
 - Richmond County (202,587)
 - Chatham County (276,434)



Findings:

Lessons Learned for CJS

- Districts as regions (LHDs join together to provide services)
- Agency culture as determinant of cross jurisdictional practices
- District role in supporting QI and accreditation readiness through CJS
- District as QI collaboratives (QI Learning Community and QI CJS)
- District based PBRN as QI Learning Community



County:

Basic LHD Jurisdiction in GA

- Statutes, regulations, executive directives tend to be primary focus of organizing authority for LHDs
- County Health Board and CHD are main statutory jurisdiction for LHDs in Georgia

Title 31 of the Georgia Statutes –

- county board of health in “each and every county” of state.
- appointment of physician as director who serves as chief executive officer
- duties of director & other employees include enforcement of county board of health regulations



Districts and GA Statutes

(districts resemble regional body of LHDs)

- Permissive vs. compulsory nature of county boards

“with the consent of the boards of health and the county authorities of the counties involved, to establish health districts comprised of one or more counties.”
- *County approval of District Director*

“The county boards of health of the constituent counties shall . . . meet in joint session to approve the selection of a director appointed by the commissioner to serve such boards in common.”



Agency Culture

- Role of Agency culture tends to be overlooked in creating and maintaining CJS;
- Although not stated in GA statutes, regional group of CHDs, organized as Districts, is only practical and viable way statutes could be enforced for CHDs;
- Agency needs and functions, along with the history of the districts, are the driving forces for District culture;
- Districts evolved differently, and within District county alignments changed regardless of statutory changes;
- Statutory change not necessary to enable CJS, very dependent on culture/history of the districts.



Examples of HR Staffing Variations among Districts

District	District Employees	County Employees Range	
		Low	High
Coastal District	92	5	153
Southeast District	142	4	21
East Central District	16	2	204

East Central District depends heavily on one county (Richmond County) for HR services for large number of staff positions, in contrast to Southeast District which relies much more extensively on District for staffing.



Role of District in LHD QI

- Previously published study of district and county health officials found that Districts were most capable entity for conducting LHD QI.
- GA DPH and GA Foundation are contractually supporting Districts as jurisdictional entities for PHAB accreditation
- Districts with large number of very small counties (some with < 2,000 people) are engaging in structured QI initiatives.



District based PBRN

- Provides a learning community
 - Monthly GA PH PBRN meetings;
 - Regular sharing and discussion of QI and accreditation efforts;
 - Systematic practice-based study of local public health system issues through research and QI approaches;
 - Current focus on building essential services and accreditation capacity.
- Serves as multi-district QI Collaborative
 - Evaluation/review of District QI implementation efforts;
 - Forum for readiness assessment for public health accreditation;
 - Forum for building capacity for public health accreditation;
 - QI initiatives supported with technical assistance where requested.



Conclusions

- Economies of Scale drive regionalization which can support CJS;
- Districts as regional group of LHDs are overlooked opportunity for building the evidence for CJS, particularly in southern part of country;
- Agency culture tends to be overlooked opportunity for LHD policy development, in deference to laws (statutes and regulations)
- Districts in Georgia are primary mechanism for supporting QI and accreditation through CJs among county boards of health/county health departments.



Contact Information

William C. Livingood, PhD
wclivingood@georgiasouthern.edu

Clinical Professor, GSU, Jiann Ping Hsu College of Public Health
Senior Research Scientist, Duval County Health Department, IPHIR
Senior Research Scientist, UFL-Jax, Center for Health Equity and Quality Research

Additional Contacts for GA PBRN:

Gulzar Shah, PhD, MStat, MS – gshah@georgiasouthern.edu
Dayna Alexander, MSPH, CHES – da01280@georgiasouthern.edu
Angie Peden, MPH – apeden@georgiasouthern.edu
Nandi Marshall, MPH, DrPH, CHES – nmarshall@georgiasouthern.edu
Lynn Woodhouse, EdD, MPH – lwoodhouse@georgiasouthern.edu